

TARC3 Medical Form
(General Medical or Physical Disability)

Name of Applicant _____

Address _____ Apt # _____

City _____ Zip Code _____ Phone _____

Medical Release

I (applicant signature) _____ do hereby authorize my physician, medical clinic, or health care provider, to release to Transit Authority of River City any medical information related to my condition that will assist in the determination of my ability to ride the city bus.

To Be Completed by a Licensed Health Care Professional Only

This medical information is being requested by TARC to determine the applicant's ability to safely and effectively use the city bus system.

Applicant has been patient of mine since: ____/____/____

Date of applicant's last physical evaluation: ____/____/____

1. Please indicate the nature of your patient's condition or disability.

(Check all that apply)

- Diabetes
- End-Stage Renal Disease
- Undergoing Cancer treatment
- Arthritis: Please specify type and area/s _____

Amputation: Please specify extremity and/or use of prosthesis _____

Neurological Condition: Cognitive Deficits? ____ Mild ____ Moderate ____ Severe

Epilepsy

Neuromuscular Condition

Muscular Condition

Pulmonary Disease: If on oxygen, how many liters per min? _____

Cardiac Disease

Kidney Disease: Dialysis? ____ Yes ____ No

Eye Condition

Seizure Disorder Type(s) of seizures? _____

How often do the seizures occur? _____

After a seizure, how long does it take before the applicant is able to function safely? _____



All TARC buses & trolleys are lift or ramp-equipped to accommodate people with impaired mobility.

Including Passengers Who Use:

- Manual wheelchairs
- Power wheelchairs
- Power scooters
- Portable Oxygen
- Walkers (all types)
- Canes (all types)
- Crutches
- Braces

Please Note: Any passenger may request use of the lift or ramp to board or exit the bus.

Are the seizures preceded by an aura? What triggers the applicant's seizure?

Yes

No

If the applicant is taking medication for the seizures, is he/she able to function safely and effectively in the community?

Yes

No

Please explain how the condition/s would prevent the applicant from being able to safely and effectively use regular city buses.

If there are other conditions that you feel would prevent the applicant from being able to safely and effectively use regular city buses, please list and explain here:

2. Is this condition/s temporary? ___Yes ___No

If temporary, what is the expected duration? _____

3. Are there any environmental conditions that would exacerbate the applicant's condition/s?

Please list:

4. Do you feel the applicant could be trained to independently use regular city buses safely and effectively?

___Yes ___No

5. How far do you feel the applicant could independently propel a wheelchair or ambulate with or without a mobility aid, and without lengthy rest breaks?

No functional mobility

_____ Blocks (500' = 1 block)

Greater than ½ mile

6. Do you feel the applicant could stand for 10 minutes or sit in a wheelchair for 10 minutes at a bus stop to wait for a regular city bus? ___ Yes ___ No

7. Please provide any additional information that you feel relevant to the applicant's ability to safely and effectively use regular city buses: _____

8. *TARC3 (paratransit) drivers assist individuals* from the door of their origin to the van, and from the van to the door of their destination. Does the applicant require additional assistance from a PCA? ___ Yes ___ No if "yes", please describe the type of assistance needed:

Name of Medical Professional Completing this Form:

Print Name: _____

Professional Title: _____

Area of Professional Specialization: _____

"I certify that the information contained herein is true and correct to the best of my knowledge and ability."

Signature _____ Date _____

Professional License, Registration or Certification Number:

_____ State _____

Clinic or Agency _____

Address _____ Suite _____

City _____ State _____ Zip _____

Phone (____) _____

Please return this medical verification to the applicant.

Thank you